In addition, a dependency in one (1) ADL shall not necessarily indicate a dependency in another area. When a checklist is used to assess individual ADL's and there is more than one (1) area checked under the same ADL, if the information is conflicting, and there is no other clarifying information available, the least dependent status indicated shall be used to score the resident. Reviewers shall not normally research ADL information beyond one (1) month prior to the target date. When the ADL information cannot be found within this one (1) month reference period, the resident shall be scored as "0" (independent) for that ADL.

The following lists the 8 Key Activities of Daily Living and a description of what each score represents. Scores have been segregated based upon whether or not they indicate that a dependency exists.

1. DRESSING (Scored from 0 through 4)

Resident Is Not Dependent If Scored As Follows:

0. Chooses and puts on own clothes
1. Clothes picked out for resident, minimal supervision required

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Resident Is Dependent If Scored As Follows:

2. Receives active help of another person
3. Totally dressed by staff (unable to participate)
4. Bed attire Code for bedfast residents only

2. GROOMING (Scored 0 through 3)

Resident Is Not Dependent If Scored As Follows:

0. Keeps self neat and clean
1. Grooms self with supervision

Resident Is Dependent If Scored As Follows:

2. Receives daily assistance of another person
3. Receives total grooming by another person (unable to participate)

3. BATHING (Scored 0 through 5)

Resident Is Not Dependent If Scored As Follows:

0. Self
1. Receives supervision with some prompts and reminders
2. Receives supervision with prompting and reminding for entire bath

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3. Receives assistance to get into and out of tub

Resident Is Dependent If Scored As Follows:

4. Receives personal help of assisting with feet, back, perineal care, etc.
5. Completely unable to bathe self

4. EATING (Scored 0 through 4)

Resident Is Not Dependent If Scored As Follows:

0. Feeds self (without need of set up assistance)

1. Feeds self but receives prompting or reminding

Resident Is Dependent If Scored As Follows:

2. Receives help to cut meat and arrange food within reach, butter bread, etc., at the time meal is delivered

3. Fed part of each meal or observed during entire meal due to risk of occasional gagging or choking

4. Fed all food by staff (Include Tube Feeding)

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5. BED MOBILITY (Scored 0 through 3)

Resident Is Not Dependent If Scored As Follows:

0. Turns and sits up in bed by self
1. Occasional help to turn and sit up

Resident Is Dependent If Scored As Follows:

2. Always receives help to turn and sit up
3. Turned and repositioned by staff

6. TRANSFERRING (Scored 0 through 4)

Resident Is Not Dependent If Scored As Follows:

0. Transfers independently (with or without mechanical device)
1. Requires physical presence of another person during transfer, needs/receives guidance only

Resident Is Dependent If Scored As Follows:

2. Transfers with aid of one person
3. Transfers with aid of two persons or total transfer mechanical device
4. Remains bedfast

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7. AMBULATION (Scored 0 through 4)

GUIDANCE TO A DESTINATION DOES NOT CONSTITUTE A DEPENDENCY IN WALKING.

Resident Is Not Dependent If Scored As Follows:

0. Independent
1. Requires the help of a device (cane, walker, crutch)

Resident Is Dependent If Scored As Follows:

2. Personal help of one person
3. Personal help of two persons
4. Unable to walk

8. TOILETING (Scored 0 through 6)

The following scoring is used except when the resident has a catheter and is continent of bowel or has an ostomy and is continent of urine in which case the resident shall receive a code of 0. However, if a continent resident with either a catheter or ostomy or both receives help to toilet, they shall receive a code of 1.

Resident Is Not Dependent If Scored As Follows:

0. Continent (include resident who manages the problem of dribbling)

Resident Is Dependent If Scored As Follows:

1. Receives help to toilet, no incontinence
2. Occasional incontinence, not more than once a week (Includes resident who receives help because of dribbling). A leaking catheter is not dribbling.
3. Nocturnal incontinence only
4. Incontinent bladder, more than once per week
5. Incontinent bowel, more than once per week (Include resident with ostomy bag that leaks more than once per week)
6. Incontinent of both bowel and bladder

D. CRITERIA FOR BEHAVIOR. For residents with present behavioral problems requiring intervention, the medical records for Behavior shall establish that:

1. The behavior problem(s) have been identified and specifically described. General statements such as "can be combative" do not meet the criteria. The reviewer shall be able to ascertain from the record what behavior occurred and the surrounding circumstances leading to the need for behavior intervention;

2. The resident's behavior has been assessed by a physician;

3. A written plan of intervention addressing the behavioral problem has been developed;

4. Progress notes indicating the resident's response to treatment have been recorded in descriptive terms by licensed nurses;

The code shall be 0 when criteria 1-4 are not met.

E. RATING BEHAVIOR NEEDS (Scored from 0 through 4). The resident shall be assigned one of the following scores based upon which one best describes the resident's current behavior.

0. Behavior requires no intervention.

1. Requires occasional intervention in the form of cues. Resident responds to cues.

2. Requires regular staff intervention in the form of redirection. Resident is resistive, but responds to redirection as stated in the plan of care.

3. Requires behavior management and staff intervention. Resident is resistant to redirection as stated in the plan of care.

4. Requires behavior management and staff intervention because resident is physically abusive to self and others. Resident physically resists redirection.

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F. CRITERIA FOR SPECIAL TREATMENTS. These are procedures that are special nursing needs rather than routine care needs. In order to establish that a resident is receiving Special Nursing Treatments, the medical record shall establish that:

1. The physician has performed a medical evaluation identifying the high risk or unstable medical condition requiring special nursing treatment, with written orders for the treatment which are signed within 14 days of the receipt of the order.

2. A registered nurse, following the plan of care, may delegate the medical and nursing functions to other team members and coordinates the care.

3. A registered nurse reassesses quarterly.

G. DEFINITION OF SPECIAL NURSING TREATMENTS. Listed below are the Special Nursing Treatments along with their definitions:

1. Tube feeding. This includes any type of tube currently being used to deliver food or nutritional substances directly into the gastrointestinal system.

2. Oxygen and Respiratory Therapy. Special nursing measures to improve respiratory function include postural drainage, nebulizers, IPPB, respirators, suctioning, and oxygen.

3. Ostomy/Catheters. If more extensive than routine ostomy or catheter care.

   Catheter care is coded only when it is more extensive than the normal care. Normal catheter care includes such activities as changing the catheter, emptying the bag, cleaning the outlet and monitoring the intake and output.

4. Wound or Pressure Ulcer of stage two or greater. Only includes therapeutic measures; not preventative measures.

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